Clinical audit on physiotherapy medical record documentation: a moving step on striving for continuous quality improvement

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Introduction
Medical record documentation is an essential element in both the health care and legal systems. It provides the most objective evidence on quality patient care and litigation defense. Much of physiotherapy practice is recorded in the patient medical record. In Kowloon Central Cluster (KCC), over 760,000 medical records entries were documented by physiotherapists in 2013-14. In 2013, a “KCC Guidelines on Medical Record Documentation” was established, listing out all mandatory requirements and standards on medical record documentation. As reported in the “Organization Wide Survey 2014” at Queen Elizabeth Hospital, regular medical records audits, including allied health professionals, were recommended.

Objectives
To evaluate the compliance of physiotherapy medical record documentation with KCC Medical Record Documentation Guidelines, and to identify areas for improvement.

Methodology
A retrospective documentation review was conducted using plan-do-check-act approach. All physiotherapy medical records of in-patients and out-patients discharged at KCC, from 18 August to 20 September 2014, were randomly selected for auditing. A “KCC Physiotherapy Clinical Audit Workgroup” which comprised of 12 experienced physiotherapists was responsible for conducting the audit. To reduce bias, they acted as independent auditor. Based on references from guidelines at corporate, cluster, and hospital levels, a 21-criteria audit form, the “Physiotherapy Medical Record Audit Form” was developed. It comprised of two major parts: “General Documentation Practice” and “Quality of Documentation Content”. Each criterion was
weighted as “observed”, “not observed” or “not applicable”. Compliance to individual criterion was then calculated as the percentage of total number of observed responses to the total number of audited records.

**Result**

Six hundred (10% of total discharged cases in the studying period) physiotherapy medical records (400 in-patients, 200 out-patients) were reviewed. 16 out of 21 criteria were of high or full compliance to the KCC Guidelines. Five areas for improvement were identified. Follow-up recommendations were made including provide regular refresher in-service training for all staff to reinforce professional standard awareness, development of pre-printed medical record forms template to include all the mandatory items, and establishment of an updated professional based abbreviation list. Regular re-auditing should also be performed to ensure continuous quality improvement.